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# Air Ambulance Reform – Why Congress Should Exempt Air Ambulances From “Carrier” Classification and Preemption Under the Airline Deregulation Act

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# AIR AMBULANCE REFORM – WHY CONGRESS SHOULD EXEMPT AIR AMBULANCES FROM “CARRIER” CLASSIFICATION AND PREEMPTION UNDER THE AIRLINE DEREGULATION ACT

ANDREW J. UPTON\*

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## I. INTRODUCTION

After an air ambulance transported Ivan Mitchell's wife from Grand Forks, North Dakota to the Mayo Clinic in Rochester, Minnesota, Mr. Mitchell received a bill for about \$54,000.<sup>1</sup> The total bill was \$67,325, but the Mitchells' insurance only covered approximately \$9,000, leaving the Mitchells on the hook for the balance.<sup>2</sup> After a cluster of cases like the Mitchells' experience, the North Dakota state legislature attempted to regulate the air ambulance industry in an effort to help its citizens afford necessary medical care in times of crisis.<sup>3</sup> The North Dakota legislature passed House Bill 1255,<sup>4</sup> requiring providers of air ambulance services "to become participating providers with certain North Dakota health insurance companies in order to be listed on a 'primary call list' for air ambulance services."<sup>5</sup> A participating provider would agree to charge only what is allowed in insurance contracts, which would leave patients responsible only for deductibles and any copayments that their policies require.<sup>6</sup> The intent behind House Bill 1255 was to "prevent patients from getting hit with exorbitant bills from out-of-network<sup>7</sup> ambulance services."<sup>8</sup>

<sup>1</sup> Patrick Springer, *N.D. Law Test Case for Preventing Air Ambulance Price 'Gouging'*, BISMARCK TRIB. (June 21, 2015), [http://bismarcktribune.com/news/state-and-regional/n-d-law-test-case-for-preventing-air-ambulance-price/article\\_2ad667ea-9fcb-534a-a88d-7225551e56a2.html](http://bismarcktribune.com/news/state-and-regional/n-d-law-test-case-for-preventing-air-ambulance-price/article_2ad667ea-9fcb-534a-a88d-7225551e56a2.html) [https://perma.cc/AH6R-ZUN9].

<sup>2</sup> *See id.*

<sup>3</sup> *See id.*

<sup>4</sup> H.B. 1255, 64th Leg. Assemb. (N.D. 2015) (codified at N.D. CENT. CODE ANN. § 23-27-04.10 (West 2016)).

<sup>5</sup> *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 934 (D.N.D. 2016).

<sup>6</sup> *See Springer, supra* note 1.

<sup>7</sup> "Out-of-network" versus "in-network" is discussed *infra* Part V., Section B.2.

<sup>8</sup> *See Springer, supra* note 1.

Like air ambulance providers across the United States, Valley Med Flight, Inc. (Valley Med), an air ambulance provider in North Dakota, is an “air carrier” under the Airline Deregulation Act of 1978 (ADA).<sup>9</sup> Valley Med filed suit against Terry Dwelle, the State Health Officer for the North Dakota Department of Health, to prevent enforcement of House Bill 1255.<sup>10</sup> Judge Hovland of the United States District Court for the District of North Dakota granted Valley Med’s Motion for Judgment on the Pleadings, holding:

The clear intent of the legislation is to prevent air ambulance service providers, who are not participating providers, from imposing exorbitant fees on patients who wrongly assume their insurance will cover the charges and are not in a position to discover otherwise. This type of consumer protection law is precisely the type of law Congress sought to preempt when it enacted the ADA.<sup>11</sup>

Judge Hovland based his decision on House Bill 1255’s effect on the prices Valley Med could charge for its services, which created a conflict with the ADA.<sup>12</sup> The ADA reads that “a State . . . may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a *price*, route, or service of an air carrier that may provide air transportation.”<sup>13</sup> The U.S. Supreme Court has discussed the broad scope of the ADA preemption clause, noting that “the key phrase ‘related to’ expresses a ‘broad pre-emptive purpose.’”<sup>14</sup> That broad preemption means that “state laws and regulations ‘having a connection with or reference to airline rates, routes, or services, are preempted by the ADA.’”<sup>15</sup> Cases like *Valley Med Flight, Inc. v. Dwelle* and experiences similar to that of Ivan Mitchell showcase the precarious position that medical patients can be left in when they require an air ambulance in order to get the treatment they deserve, and their state lawmakers are unable to do anything about it.

While preemption of state law is an oft-discussed topic, little has been written about the specific preemption of air ambu-

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<sup>9</sup> See *Dwelle*, 171 F. Supp. 3d at 934.

<sup>10</sup> See *id.*

<sup>11</sup> *Id.* at 942.

<sup>12</sup> See *id.* at 941–42.

<sup>13</sup> 49 U.S.C. § 41713(b)(1) (2012) (emphasis added).

<sup>14</sup> *Northwest, Inc. v. Ginsberg*, 134 S. Ct. 1422, 1424 (2014) (quoting *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992)).

<sup>15</sup> *Dwelle*, 171 F. Supp. 3d at 939 (quoting *Morales*, 504 U.S. at 383).

lance regulations under the ADA. Most articles highlight personal experiences of patients transported by air ambulances, with just a passing mention of the ADA or state attempts to regulate the industry. There have also been other articles that discuss pending cases, written before those cases were adjudicated by the courts. One article discusses service preemption under the ADA with respect to food allergies on flights.<sup>16</sup> While this discussion has similar underlying themes with the allergy preemption article, the focuses are different and distinguished enough to provide ample room for comment.

This article discusses the ins and outs of the air ambulance industry, explains the status of air ambulance industry regulatory laws, and details why, in light of judicial precedent and industry practices, Congress should exempt air ambulances from being classified as “carriers” under the ADA, so that state attempts to regulate the air ambulance industry for the protection of their citizens are no longer preempted by a law aimed to promote commercial competition. Part II traces the development of the air ambulance industry from its wartime start to the present day. Part III discusses briefly the different ways in which an air ambulance provider receives payment for its services, as a means of providing background for the impetus behind the state attempts discussed in Part IV. Part IV lays out the legal framework for ADA preemption based on Supreme Court precedent and developments in lower courts related to attempts by states to circumvent the ADA. Part V explains why, given legislative intent, industry practices, and judicial precedent, exempting air ambulances from the ADA is the logical move.

## II. DEVELOPMENT OF THE AIR AMBULANCE INDUSTRY

The carnage that accompanied World War I brought with it a new innovation: the first instance of an aircraft transporting medical patients when “an open cockpit biplane was used to rescue injured soldiers and bring them to field hospitals.”<sup>17</sup> Fast forward nearly sixty years, and the first non-military dedicated air ambulances began flying across the skies.<sup>18</sup> An “air ambu-

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<sup>16</sup> See Laci Verduco Resendiz, Comment, *Food Allergies on Flights—How A Narrow Interpretation of “Service” Preemption Under the Airline Deregulation Act Could Give Allergic Passengers Much Needed Protection*, 81 J. AIR L. & COM. 321 (2016).

<sup>17</sup> Todd Lovshin, *Air Ambulance Providers: Providers’ Refusal to Contract with Insurers Costing Many Montanans Thousands*, 41 MONT. LAWYER 32 (2016).

<sup>18</sup> See *id.* (stating that “[i]n 1973 the first civil airplanes dedicated to emergency medical services began operations”).

lance” is exactly what it sounds like: helicopters or planes that transport patients (and in some cases, donated organs) to and from the hospital or scene of an accident.<sup>19</sup> Air ambulances are more than just aircraft designated specifically for transporting medical patients; they are also “equipped with state-of-the-art medical equipment and staffed by paramedics, emergency medical technicians and sometimes doctors and nurses.”<sup>20</sup> This equipment allows air ambulances to effectively transport “patients with time critical injuries and conditions to medical facilities” as well as “provid[e] patients with advanced care while en route.”<sup>21</sup> The advanced technology and qualified medical personnel onboard the ambulances has led to the widely-held belief that air ambulances “improve the chances of survival for trauma victims and other critical patients,”<sup>22</sup> such as those with “pregnancy complications, heart attacks, strokes and respiratory diseases.”<sup>23</sup> As of 2014, more than 550,000 patients per year are transported via air ambulances,<sup>24</sup> a number that has grown over the years.<sup>25</sup> The increasing usage of air ambulances has pushed the regulation issue to the forefront and necessitates action.

### III. PAYING FOR AIR AMBULANCE SERVICES IS COMPLICATED

By their nature, medical services are expensive, and paying for them can be complicated and involve multiple sources. The average distance covered by an air ambulance trip is fifty-two miles, and will cost between \$12,000 to \$25,000 per flight, before insurance kicks in.<sup>26</sup> Air ambulance providers garner pay-

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<sup>19</sup> U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-09-627T, AVIATION SAFETY: POTENTIAL STRATEGIES TO ADDRESS AIR AMBULANCE SAFETY CONCERNS 1 (2009).

<sup>20</sup> *Consumer Alert: Understanding Air Ambulance Insurance*, NAT'L ASS'N. OF INS. COMM'RS (Apr. 2., 2014), [http://www.naic.org/documents/consumer\\_alert\\_understanding\\_air\\_ambulance\\_insurance.htm](http://www.naic.org/documents/consumer_alert_understanding_air_ambulance_insurance.htm) [<https://perma.cc/DR3K-PXK5>].

<sup>21</sup> U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-10-907, AIR AMBULANCE: EFFECTS OF INDUSTRY CHANGES ON SERVICES ARE UNCLEAR 3 (2010) [hereinafter GAO-10-907].

<sup>22</sup> *Id.*

<sup>23</sup> *Consumer Alert: Understanding Air Ambulance Insurance*, *supra* note 20.

<sup>24</sup> *Id.*

<sup>25</sup> See GAO-10-907, at 3 (stating that “[a]ir ambulances transported more than 270,000 patients in 2008”).

<sup>26</sup> *DIFS Consumer Counselor Insurance Information Sheet: Understanding Coverage for Air Ambulance Services*, MICH. DEP'T INS. & FIN. SERVS. (July 2015), [https://www.michigan.gov/documents/difs/Air\\_Ambulance\\_Insurance\\_482626\\_7.pdf](https://www.michigan.gov/documents/difs/Air_Ambulance_Insurance_482626_7.pdf) [<https://perma.cc/KHF5-JGVX>]; see also *Consumer Alert: Understanding Air Ambulance Insurance*, *supra* note 20.

ment for their services in several ways, including, among others, Medicare, private health insurance, and the patient himself.<sup>27</sup>

“Medicare is the principal government program that helps pay for healthcare furnished by nongovernment providers.”<sup>28</sup> There are a number of ways that an individual can qualify for Medicare coverage. A person can “automatically qualify for Medicare Part A” upon reaching the age of sixty-five.<sup>29</sup> Those who qualify for Part A coverage “are automatically enrolled in Part B when they become eligible for Part A unless they opt out.”<sup>30</sup> Some individuals who do not qualify for Medicare coverage on their own have the ability to purchase coverage.<sup>31</sup> Additionally, some “state Medicaid programs . . . buy Medicare coverage for low-income individuals . . .”<sup>32</sup> Ambulance services, if covered, fall under Medicare Part B.<sup>33</sup>

Medicare *may* cover transportation by air ambulance if the patient’s condition necessitates ambulance transport that cannot be accommodated by ground ambulance and one of the following conditions applies: either (1) ground transport cannot easily reach the patient’s pickup location; or (2) distance or obstacles could interfere with ground transportation efforts and prevent the patient from getting care quickly.<sup>34</sup> Transport by air ambulance is also “limited to taking the patient to the nearest appropriate facility.”<sup>35</sup> While not listed explicitly under the details of air ambulance coverage, the Medicare website does include a caveat to the section on “emergency ambulance transportation”—“Medicare coverage depends on the seriousness of your medical condition and whether you could’ve been safely transported by other means.”<sup>36</sup> This caveat serves as a yellow flag for Medicare patients, as the website does not state explicitly that Medicare *will* “pay for emergency ambulance transportation in

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<sup>27</sup> See GAO-10-907, at 5 fig.1 (reproduced *infra* Figure 1).

<sup>28</sup> TERRY S. COLEMAN, MEDICARE LAW 1 (2001).

<sup>29</sup> See *id.* at 2 (“Individuals age sixty-five or over who qualify for Social Security or Railroad Retirement monthly cash retirement benefits automatically qualify for Medicare Part A.”).

<sup>30</sup> *Id.* at 3.

<sup>31</sup> See *id.*

<sup>32</sup> *Id.* at 4.

<sup>33</sup> See *id.* at 20 (“§ 2:2 The Part B Benefits Package”), 34 (“§ 2:2(f)(1) Ambulance”).

<sup>34</sup> See U.S. CENTERS FOR MEDICARE & MEDICAID SERVS., *Your Medicare Coverage, Ambulance Services*, <https://www.medicare.gov/coverage/ambulance-services.html> [<https://perma.cc/6VH8-JLXB>] (last visited July 7, 2017).

<sup>35</sup> COLEMAN, *supra* note 28, at 35.

<sup>36</sup> *Your Medicare Coverage, Ambulance Services*, *supra* note 34.

an airplane or helicopter,” but rather that “Medicare *may* pay for emergency ambulance transportation in an airplane or helicopter . . . .”<sup>37</sup> That small difference in wording, combined with the caveat, will force patients in critical situations to utilize whatever forms of emergency medical transport they can get, and hope that Medicare will provide coverage. Nevertheless, patients ultimately will not know for sure if they are covered until after the fact.

For those who are not enrolled in Medicare, their use of air ambulances may be covered in whole or in part by their private insurance, and if they do not have applicable insurance, the entire cost will come out-of-pocket.<sup>38</sup> “Balance billing” is when a provider of medical services bills the patient for the “difference between the provider’s charges and the amount” covered by insurance, or covered by an organization’s fee schedule.<sup>39</sup> “For example, if the provider’s charge is \$100 and the allowed amount is \$70, the provider may bill [the patient] for the remaining \$30.”<sup>40</sup>

Figure 1, below, illustrates the many sources from which air ambulance providers collect payment in order to satisfy a patient’s bill.

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<sup>37</sup> *Id.* (emphasis added).

<sup>38</sup> See Steve Jordon, *Few Think About Insurance When Air Ambulance Lifts Off; Then . . . Surprise*, OMAHA WORLD HERALD (Nov. 24, 2014), [http://www.omaha.com/money/few-think-about-insurance-when-air-ambulance-lifts-off-then/article\\_11759ecf-182f-59a2-8cde-7c804ecf9913.html](http://www.omaha.com/money/few-think-about-insurance-when-air-ambulance-lifts-off-then/article_11759ecf-182f-59a2-8cde-7c804ecf9913.html) [<https://perma.cc/CX4B-ACJG>] (Nebraska’s insurance director saying that some individuals “have found that there’s a huge balance to pay even after their health insurance pays.”).

<sup>39</sup> *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 937 (D.N.D. 2016); see also *Balance Billing*, HEALTHCARE.GOV GLOSSARY, <https://www.healthcare.gov/glossary/balance-billing/> [<https://perma.cc/HB3X-GQJZ>] (last visited July 7, 2017).

<sup>40</sup> *Balance Billing*, *supra* note 39.



Figure 1: Percentage of Payments for Air Ambulance Transports Received from Different Sources<sup>41</sup>

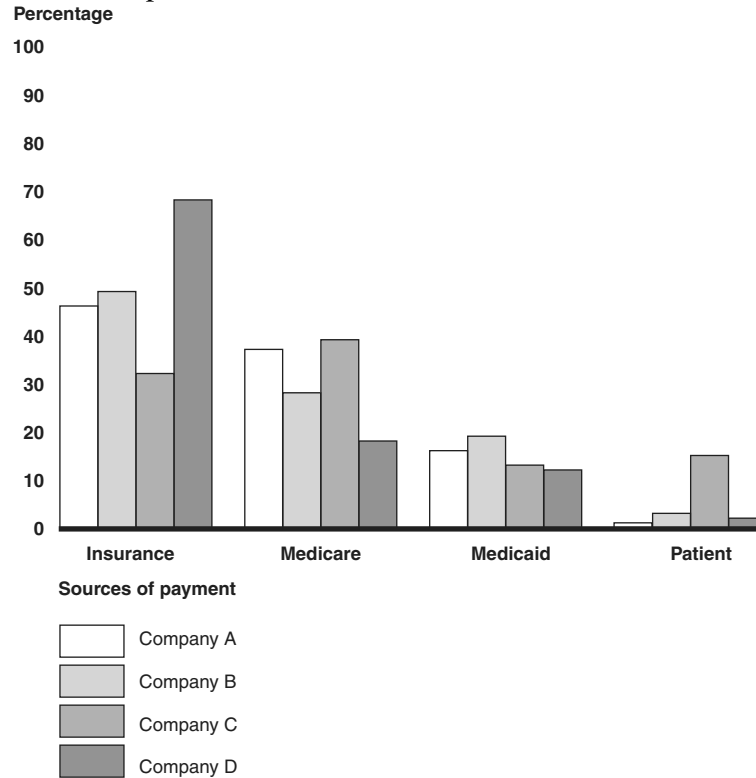


Figure 1 shows the percentage of payment received by four air ambulance providers from each of four sources: private insurance, Medicare, Medicaid, and from the patient himself (which would be the amount that was “balance billed” after the other sources made their contributions). Figure 1 shows the unique nature of each air ambulance transport, and how each source of payment does not necessarily contribute the same amount or percentage in every patient’s case.

#### IV. WHAT IS THE LEGAL FRAMEWORK FOR PREEMPTION UNDER THE AIRLINE DEREGULATION ACT?

As *Valley Med Flight, Inc. v. Dwelle* illustrates, states at first glance appear to have little to no options for regulating<sup>42</sup> the

<sup>41</sup> GAO-10-907, at 5 fig.1.

<sup>42</sup> For purposes of this discussion, unless otherwise noted, any mention of regulating the air ambulance industry refers to regulating the prices and rates associated with air ambulance services, as states are free to regulate other aspects of the

costs associated with the air ambulance industry on their own due to the ADA.<sup>43</sup> As the following sections discuss, state regulation of air ambulance costs unfortunately appears to be nearly impossible at this time. There may be a glimmer of hope for states wanting to do something to help their citizens, but it is not without its own potential legal hurdles to conquer when the time comes.<sup>44</sup>

A. THE SUPREMACY CLAUSE AND THE ADA EXPRESSLY PREEMPT  
STATE REGULATION OF THE AIR AMBULANCE INDUSTRY,  
BECAUSE AIR AMBULANCES ARE “CARRIERS”

Preemption of state law is possible because of the Supremacy Clause,<sup>45</sup> which “invalidates state laws that interfere with, or are contrary to, federal law.”<sup>46</sup> In 1978, Congress came to the conclusion that “deregulation of the airline industry would lead to greater reliance on market forces resulting in greater efficiency, innovation, lower prices, and enhanced quality and variety of air transportation services,” and passed the ADA.<sup>47</sup> The ADA dictates that “a State . . . may not enact or enforce a law, regulation, or other provision having the force and effect of law related to a *price*, route, or service of an air carrier that may provide air transportation.”<sup>48</sup> The ADA therefore has an express preemption clause, meaning that Congress has explicitly stated that the ADA preempts state law.<sup>49</sup>

Specifically, the ADA is concerned with “air carrier[s].”<sup>50</sup> While the ADA is silent as what constitutes an “air carrier,”<sup>51</sup> Title 49 defines the term as “a citizen of the United States undertaking by any means, directly or indirectly, to provide air transportation.”<sup>52</sup> “As a general rule an air carrier is a common carrier . . . .”<sup>53</sup> Title 49 supports this statement, referencing “air-

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industry. See GAO-10-907, at 23, 37; Lovshin, *supra* note 17, at 34 (“states do have limited regulatory authority over air ambulance providers around medical and quality standards of care”).

<sup>43</sup> See *Dwelle*, 171 F. Supp. 3d at 941–42.

<sup>44</sup> See *infra* Part V., Section B.3.

<sup>45</sup> U.S. CONST. art. VI, cl. 2.

<sup>46</sup> *Dwelle*, 171 F. Supp. 3d at 938 (internal quotations omitted).

<sup>47</sup> *Id.* (citing *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992)).

<sup>48</sup> 49 U.S.C. § 41713(b)(1) (2012) (emphasis added).

<sup>49</sup> See *Dwelle*, 171 F. Supp. 3d at 938.

<sup>50</sup> See 49 U.S.C. § 41713(b)(1).

<sup>51</sup> See *id.*

<sup>52</sup> 49 U.S.C. § 40102(a)(2) (2012).

<sup>53</sup> THOMAS A. DICKERSON, TRAVEL LAW § 2.05 (2016).

craft [acting] as a common carrier for compensation.”<sup>54</sup> While that statute does not define the term, “it has been said that a common carrier . . . holds [itself] out to the public as engaged in the business of transporting persons or property from place to place, for compensation, offering [its] services to the public generally.”<sup>55</sup> “The public, however, does not mean everybody all the time.”<sup>56</sup> It is irrelevant whether the entire population will utilize the service, or whether it is a specialized service like air ambulances.<sup>57</sup> Therefore, air ambulances are considered to be carriers under federal legislation.<sup>58</sup>

## B. SUPREME COURT PRECEDENT

The U.S. Supreme Court has weighed in on how the ADA’s express preemption clause should be construed in three cases.<sup>59</sup> The Supreme Court first took up the issue of the scope of ADA preemption in *Morales v. Trans World Airlines, Inc.*<sup>60</sup> In *Morales*, the Supreme Court explained that the broad applicability of the ADA’s preemption language prevents states from enforcing legislation “relating to rates, routes, or services of any air carrier . . . .”<sup>61</sup> The Court found that the key words “relating to” have a broad plain language meaning, which in turn gives rise to “a broad pre-emptive purpose.”<sup>62</sup> The Court rejected the argument that the ADA only preempts state laws that “actually prescrib[e] rates, routes, or services” because such an interpretation would have the effect of eliminating the words “relating to” from the ADA.<sup>63</sup> That effect would go against the Court’s own rules of

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<sup>54</sup> See 49 U.S.C. § 40102(a)(25).

<sup>55</sup> D. E. Buckner, Annotation, *Air Carrier as Common or Private Carrier, and Resulting Duties as to Passenger’s Safety*, 73 A.L.R. 2d 346 (1960) (internal quotations omitted).

<sup>56</sup> *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 733 (E.D.N.C. 2008) (quoting *Terminal Taxicab Co. v. Kutz*, 241 U.S. 252, 255 (1916)) (internal citations omitted).

<sup>57</sup> See *id.*

<sup>58</sup> See *id.* at 732; *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 933 (D.N.D. 2016).

<sup>59</sup> See *Northwest, Inc. v. Ginsberg*, 134 S. Ct. 1422 (2014); *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219 (1995); *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374 (1992).

<sup>60</sup> *Morales*, 504 U.S. 374.

<sup>61</sup> *Id.* at 383 (emphasis added) (internal quotations omitted).

<sup>62</sup> *Id.*

<sup>63</sup> *Id.* at 385.

construction.<sup>64</sup> The Court expressed its findings simply: “State enforcement actions having a connection with or reference to airline rates, routes, or services are pre-empted” by the ADA.<sup>65</sup>

The Supreme Court next considered the scope of ADA preemption in *American Airlines, Inc. v. Wolens*.<sup>66</sup> The statute at issue in *Wolens*, the Illinois Consumer Fraud Act,

declare[d] unlawful “[u]nfair methods of competition and unfair or deceptive acts or practices, including but not limited to the use or employment of any deception, fraud, false pretense, false promise, misrepresentation or the concealment, suppression or omission of any material fact, with intent that others rely upon [it] . . . in the conduct of any trade or commerce . . . whether any person has in fact been misled, deceived or damaged thereby.”<sup>67</sup>

The Court found that Illinois’ Consumer Fraud Act was “pre-scriptive; it controls the primary conduct of those falling within its governance” and “serves as a means to guide and police the marketing practices of the airlines . . . .”<sup>68</sup> The Court held that the ADA preempted claims under the Consumer Fraud Act because the purpose behind the ADA was to “to leave largely to the airlines themselves, and not at all to States, the selection and design of marketing mechanisms appropriate to the furnishing of air transportation services . . . .”<sup>69</sup> The Court agreed with American Airlines that “Congress could hardly have intended to allow the States to hobble [competition for airline passengers] through the application of restrictive state laws,”<sup>70</sup> when promotion of “competitive market forces” underlies the ADA itself.<sup>71</sup> A stable and efficient market depends on enforcing freedom of contract ideals, a reality that “is key to sensible construction of the ADA.”<sup>72</sup>

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<sup>64</sup> *Id.* at 383 (“The question . . . is one of statutory intent, and we accordingly begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.” (internal quotations omitted)).

<sup>65</sup> *Id.* at 384 (internal quotations omitted).

<sup>66</sup> 513 U.S. 219, 221–22 (1995).

<sup>67</sup> *Id.* at 227 (citing ILL. COMP. STAT., ch. 815, § 505/2(1992) (formerly codified at ILL. REV. STAT., ch. 121 1/2, 262 (1991))).

<sup>68</sup> *Id.* at 227–28.

<sup>69</sup> *Id.* at 228.

<sup>70</sup> *Id.* (alteration in original) (quoting Brief for Petitioner at 27, *Wolens*, 513 U.S. 219 (No. 93-1286)).

<sup>71</sup> *Id.* at 230.

<sup>72</sup> *Id.*

Finally, the Supreme Court again considered the broad preemptive range of the ADA in *Northwest, Inc. v. Ginsberg*.<sup>73</sup> The Court had “little difficulty rejecting” the argument that ADA preemption only applies to laws enacted by state legislatures and to state administrative agency regulations, and not to common law developments.<sup>74</sup> The ADA preempts state “‘law[s], regulation[s], or other provision[s] having the force and effect of law,’”<sup>75</sup> and the Court noted that it is normal practice to refer to common law developments as “provisions.”<sup>76</sup> Further, the Court noted that common law developments have “the force and effect of law” that the ADA prohibits.<sup>77</sup> The Court elaborated, pointing out that the central purpose of the ADA would not be served by exempting common law rules or developments from its purview.<sup>78</sup> In the eyes of the Court, exempting common law rules would provide the states with a way to undo the deregulation intended by the ADA.<sup>79</sup> The effect of exempting common law rules from ADA preemption would therefore allow some modicum of state regulation of prices, routes, and/or services, rather than allowing the forces of the free market to dictate prices, routes, and services.<sup>80</sup> The Court recognized this, and stated the importance of “the effect of a state law, regulation, or provision, not its form[:] . . . [T]he ADA’s deregulatory aim can be undermined just as surely by a state common-law rule as it can by a state statute or regulation.”<sup>81</sup>

These three Supreme Court cases explored the broad scope of ADA preemption.<sup>82</sup> Are there any niches left unmapped? As the next section discusses, states have tried to find where the line is drawn in order to avoid preemption, yet still exert some facet of control over the air ambulance industry.

### C. ATTEMPTS TO CHANGE HAVE MIXED RESULTS

Lawmakers at both the state and federal level have attempted to effectuate change in terms of state regulation of the air ambu-

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<sup>73</sup> 134 S. Ct. 1422 (2014).

<sup>74</sup> *See id.* at 1429.

<sup>75</sup> *Id.* (alterations in original) (quoting 49 U.S.C. § 41713(b)(1)).

<sup>76</sup> *Id.*

<sup>77</sup> *Id.*

<sup>78</sup> *Id.* at 1430.

<sup>79</sup> *See id.*

<sup>80</sup> *See id.*

<sup>81</sup> *Id.*

<sup>82</sup> *See id.* at 1428–29.

lance industry. Unfortunately, these attempts have mostly been met with precedent-deferential courts or a lack of information, both leading to the same result: disallowance of state regulations of the air ambulance industry, with one exception.<sup>83</sup>

1. *State Level*<sup>84</sup>

Several states have attempted to regulate the air ambulance industry in some way, shape, or form, and seemingly each attempt to regulate is met with resistance by the courts. While the most common attempt comes via statutory enactment passed by the state legislature, there are subtle nuances between the approaches, and some attempts eschew the legislature altogether and come from the administrative side. Further, Montana has passed a statute that does not seek to regulate the air ambulance industry, but gives incentives for air ambulance providers to make their services more affordable to Montana residents.<sup>85</sup>

a. North Dakota

North Dakota lawmakers passed a law that gave the North Dakota Department of Health the authority to create a “primary call list” of air ambulance providers.<sup>86</sup> The statute required that for an air ambulance provider to qualify for inclusion on the primary call list, the provider must become “a participating provider of the health insurance carriers in the state which collectively hold at least seventy-five percent of the health insurance coverage in the state as determined by annual market share reports.”<sup>87</sup> A participating provider agrees to charge only what is allowed in the insurance contracts of the carriers the provider joins, which would leave patients responsible only for deductibles and any copayments that their policies require.<sup>88</sup>

The statute also laid out a protocol for emergency medical services personnel to follow when arranging for an air ambulance:

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<sup>83</sup> See *infra* Part IV., Section C.1.f.

<sup>84</sup> This discussion is not meant to be an exclusive or exhaustive list of every state attempt at air ambulance regulation. There may be other states that have attempted regulation, but the states included herein are the prominent examples.

<sup>85</sup> MONT. CODE ANN. § 50-6-320 (West 2015).

<sup>86</sup> N.D. CENT. CODE ANN. § 23-27-04.10(1) (West 2016).

<sup>87</sup> § 23-27-04.10(2).

<sup>88</sup> See Springer, *supra* note 1.

(1) First, the recipient of the request shall call an air ambulance service provider listed on the primary call list which is within the designated response zone.

(2) Second, if each of the air ambulance service providers listed on the primary list is not available or is not able and willing to respond to the call, the recipient of the request shall notify the requester of this fact and shall call an air ambulance provider listed on the secondary call list within the designated response zone.

(3) Third, if each of the air ambulance service providers listed on the secondary list is not available or is not able and willing to respond to the call, the recipient of the request shall notify the requester of this fact and shall inform the requester of primary and secondary air ambulance service provider options outside the designated response zone.<sup>89</sup>

This protocol leads to medical personnel targeting participating providers first, and means medical personnel can contact providers on the secondary list only when the entirety of the primary list has turned down the call.<sup>90</sup> The statute throws another wrinkle at air ambulance providers, as it instructs the Department of Health to “establish air ambulance service response zones . . . based on response times and patient health and safety.”<sup>91</sup> Providers who are outside the response zone organized by the Department of Health become the tertiary option.<sup>92</sup>

This protocol and the participating provider mandate prompted Valley Med Flight, Inc. to file suit seeking to prevent North Dakota from enforcing the statute.<sup>93</sup> In North Dakota, the carrier Blue Cross Blue Shield controls a majority of the health insurance market.<sup>94</sup> Therefore, in order to comply with the North Dakota statute, an air ambulance provider wanting to operate in North Dakota “must become a participating provider with [Blue Cross Blue Shield] in order to be listed on the primary call list.”<sup>95</sup> This meant that in order for Valley Med to get on the primary call list, it had to agree with Blue Cross Blue Shield on reimbursement rates.<sup>96</sup> However, the forced agree-

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<sup>89</sup> § 23-27-04.10(4)(b).

<sup>90</sup> § 23-27-04.10(4)(b)(2).

<sup>91</sup> § 23-27-04.10(4).

<sup>92</sup> § 23-27-04.10(4)(b)(3).

<sup>93</sup> See *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 934 (D.N.D. 2016).

<sup>94</sup> See *id.* at 936 (“Blue Cross Blue Shield of North Dakota (“BCBS”) controls more than 50% of the health insurance market in North Dakota.”).

<sup>95</sup> *Id.*

<sup>96</sup> See *id.* at 936–37.

ment led to Valley Med accepting reimbursement rates with Blue Cross Blue Shield that were “substantially below the market rate,” so much so that it would be unable to continue operating if it had to accept these rates.<sup>97</sup>

While North Dakota argued that providers make “a business decision” when they choose to become participating providers, the United States District Court for the District of North Dakota ruled that when that is the only choice other than discontinuing operations, it is no choice at all.<sup>98</sup> Participating providers on the primary call list have a “competitive advantage” over providers on the secondary call list.<sup>99</sup> That competitive advantage means that participating providers will receive more calls, while providers on the secondary list are only contacted when the entire primary list refuses the call. This severely restricts the ability of providers to offer their services.<sup>100</sup> The court held that North Dakota interfered with the market participation of air ambulance providers, which “is precisely the type of state regulation Congress sought to prevent when it included an express preemption clause in the ADA.”<sup>101</sup>

The District Court went even further, finding that the North Dakota statute was preempted on pricing grounds as well.<sup>102</sup> The court said that the North Dakota statute indirectly impacted the prices charged by air ambulance providers by forcing them to accept the reimbursement rates of carriers in order to become participating providers.<sup>103</sup> While the statute’s plain language did not restrict the rates an air ambulance provider could charge, *Ginsberg* instructed the court that the effect, rather than the form, of a state law is what is important when analyzing preemption.<sup>104</sup>

#### b. North Carolina

A North Carolina statute stated, “[n]o person shall offer or develop a new institutional health service without first obtaining

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<sup>97</sup> *Id.* at 937.

<sup>98</sup> *See id.* at 941.

<sup>99</sup> *Id.*

<sup>100</sup> *See id.*

<sup>101</sup> *Id.*

<sup>102</sup> *See id.* at 941–42.

<sup>103</sup> *See id.* (“There can be little question Section 23-27-04.10 effects [sic] Valley Med’s prices and thus relates to price under the ADA.”).

<sup>104</sup> *See id.* at 941 (citing *Northwest, Inc. v. Ginsberg*, 134 S. Ct. 1422, 1430 (2014)).



a certificate of need from the Department . . . .”<sup>105</sup> “New institutional health service[ ]” is defined to include air ambulances.<sup>106</sup> The United States District Court for the Eastern District of North Carolina held that the purposes behind requiring a certificate of need “directly contravene the pro-competition purposes underlying the ADA.”<sup>107</sup> The court held that because the North Carolina statute prescribed behavior that was necessary for an air ambulance provider to operate within the state, it was related to price, route, or service under the ADA and thus preempted.<sup>108</sup> The statute substituted the commands of the government for the market forces that justify the ADA.<sup>109</sup>

c. Wyoming

Wyoming Statute Section 27-14-401(e) dictated that “[i]f transportation by ambulance is necessary, the division shall allow a reasonable charge for the ambulance service at a rate not in excess of the rate schedule established by the director under the procedure set forth for payment of medical and hospital care.”<sup>110</sup> The fee schedule adopted for air ambulance providers set maximum allowable reimbursement rates.<sup>111</sup> While air ambulance providers would submit bills to the Worker’s Compensation Division in excess of the maximum rate allowed under the fee schedule, the Division would only pay the amounts allowed.<sup>112</sup> Under the Wyoming statute, “ambulance services are not considered ‘medical and hospital care,’” so air ambulance providers are not allowed to balance bill injured workers who use their services.<sup>113</sup> This statutory limit restricts the amount that air ambulance providers can receive in exchange for their ser-

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<sup>105</sup> N.C. GEN. STAT. ANN. § 131E-178(a) (West 2016) (effective July 5, 2007).

<sup>106</sup> N.C. GEN. STAT. ANN. § 131E-176(16)(f1)(1) (West 2005) (effective to June 18, 2009) (note that this provision is still present in the current codification of the statute).

<sup>107</sup> *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 736 (E.D.N.C. 2008).

<sup>108</sup> *See id.*

<sup>109</sup> *See id.*

<sup>110</sup> WYO. STAT. ANN. § 27-14-401(e) (West 2016).

<sup>111</sup> *EagleMed, LLC v. Wyoming*, No. 15-CV-26-ABJ, slip op. at 3 (D. Wy. May 16, 2016) (found at <http://leg.mt.gov/content/Committees/Interim/2015-2016/Economic-Affairs/Committee-Topics/Ambulance/WYwork-comp-court-case5-16.pdf> [<https://perma.cc/UUZ8-NYJR>]).

<sup>112</sup> *Id.*, slip op. at 3–4.

<sup>113</sup> *Id.*, slip op. at 25.

vices, setting up a collision course with ADA preemption.<sup>114</sup> The United States District Court for the District of Wyoming found that by restricting balance billing, the statute was dictating the maximum rate that air ambulance providers operating within Wyoming could charge for their services, and held that such rate restrictions were preempted by the ADA.<sup>115</sup>

d. Minnesota

In *Hiawatha Aviation of Rochester, Inc. v. Minnesota Department of Health*,<sup>116</sup> the State Commissioner of the Department of Health denied a provider's application to operate an air ambulance service in Minnesota. Based on a predecessor to the ADA, the Supreme Court of Minnesota ruled that the state, and by extension, the Commissioner of the Department of Health, was "preempted from controlling entry into the field of air ambulance service . . . ." <sup>117</sup> However, the state supreme court also noted that this ruling did not "oust the state from its traditional role in the delivery of medical services-the [sic] regulation of staffing requirements, the qualifications of personnel, equipment requirements, and the promulgation of standards for maintenance of sanitary conditions."<sup>118</sup>

e. Florida

In Florida, following a fatal motorcycle accident, a plaintiff's estate sought declaratory judgment that the billing practices of an air ambulance provider violated state statutes related to personal injury protection.<sup>119</sup> The United States District Court for the Southern District of Florida held that there was only one way to view the plaintiff's claims: as challenging the rates of the air ambulance provider for its services.<sup>120</sup> The court said that allowing the claims to proceed "would naturally affect the provision of [the provider's] services in addition to the prices of and

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<sup>114</sup> *Id.*, slip op. at 30 ("Because the air ambulances cannot collect above the amount the defendants have set in their fee schedules, the statute and regulations are directly related to air carrier prices.").

<sup>115</sup> *Id.*, slip op. at 33.

<sup>116</sup> 389 N.W.2d 507, 508 (Minn. 1986).

<sup>117</sup> *Id.* at 509.

<sup>118</sup> *Id.*

<sup>119</sup> *Bailey v. Rocky Mountain Holdings, LLC*, 136 F. Supp. 3d 1376, 1378–79 (S.D. Fla. 2015).

<sup>120</sup> *See id.* at 1382.

payment for those services.”<sup>121</sup> This led the court to view the Plaintiff’s claims as an enforcement action under state law.<sup>122</sup> Such actions are “expressly disallowed by the ADA’s express preemption provision, which intentionally leaves the price of such services to the competitive market.”<sup>123</sup>

f. Colorado

The Colorado example is different from the other state examples discussed above. Colorado’s statute required all air ambulance providers be licensed to operate in the state, and that the provider must complete an accreditation process by the commission on accreditation of medical transport systems.<sup>124</sup> Eagle Air Med Corporation, an air ambulance provider, filed suit alleging that the Colorado statute was preempted by the ADA and seeking a declaratory judgment.<sup>125</sup> The defendants moved to stay the action.<sup>126</sup> The United States District Court for the District of Colorado noted that the Supreme Court has previously said that “only those state laws having a ‘significant effect’ or a ‘significant impact’ on the prices, routes, or services, of an air carrier were preempted under the ADA.”<sup>127</sup> The Colorado court construed the *Morales* language as indicating that the scope of ADA preemption was narrower than the statute suggests.<sup>128</sup> The Colorado court held “that the ADA’s preclusion of state regulation of carrier ‘price, route, or service’ [did not] conclusively equate[ ] to state regulation” of air ambulances.<sup>129</sup> Therefore, the court declined to issue a declaratory judgment and granted the defendants’ motion to stay the action.<sup>130</sup> In other words, the Colorado court found that ADA preclusion might not be as broad as the Supreme Court suggested in *Morales*, and since the Colorado statute did not outright have a significant effect or impact on the prices, routes, or services provided by Eagle Air Med Corpo-

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<sup>121</sup> *Id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> COLO. REV. STAT. ANN. § 25-3.5-307(1)(a) (West 2007) (effective to May 31, 2016).

<sup>125</sup> Eagle Air Med Corp. v. Colorado Bd. of Health, 570 F. Supp. 2d 1289, 1290 (D. Colo. 2008).

<sup>126</sup> *Id.*

<sup>127</sup> *Id.* at 1292 (citing *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 388, 390 (1992)).

<sup>128</sup> *Id.*

<sup>129</sup> *Id.* at 1293.

<sup>130</sup> *Id.* at 1295.

ration, the ADA did not clearly preempt the Colorado statute at the time of the filing.<sup>131</sup> Since *Eagle Air Med Corp. v. Colorado Board of Health*, the Colorado legislature has subsequently amended Section 25-3.5-307.<sup>132</sup> The current statute simplifies the accreditation language, removing the commission on accreditation of medical transport systems language, and adding generic references to a department-approved accrediting organization and compliance with rules set by the board.<sup>133</sup>

g. Montana

Seeing “a need to assist Montana consumers with regard to the availability and affordability of air ambulance service[s],”<sup>134</sup> the Montana Legislature passed a law exempting air ambulance providers from insurance statutes.<sup>135</sup> Unlike some of the legislation passed by other states discussed in this section, Montana’s statute does not attempt to regulate the air ambulance industry, but rather seeks to entice air ambulance providers to create membership programs that will make air ambulance services more affordable.<sup>136</sup> A concern<sup>137</sup> with air ambulance membership programs is, as Mr. Lovshin states: “You are covered only if that company is the one to transport you. . . . If a different company (of the 14 currently operating in Montana) provides the service, you have no coverage.”<sup>138</sup> However, Mr. Lovshin is incorrect, at least in terms of the Montana statute. Section 50-6-320(3) of the Montana Health and Safety Code states: “Any private air ambulance service membership program must have arrangements with other air ambulance service providers in Montana to the extent reasonably possible to ensure maximum geographic coverage within the state for the subscribers to the

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<sup>131</sup> *Id.* at 1292–93 (“There remains at least a question whether the subject Colorado statute and regulations, which specifically relate only to emergency medical air transport, frustrate these objectives or any other objective of the ADA. This certainly must be taken into account in determining whether it is ‘facially conclusive’ that Colorado’s statute and regulations are preempted by 49 U.S.C. § 41713(b)(1).”).

<sup>132</sup> See 2016 Colo. Legis. Serv. ch. 206 (H.B. 16-1280) (West).

<sup>133</sup> See *id.*; COLO. REV. STAT. ANN. § 25-3.5-307(1)(a) (West 2016).

<sup>134</sup> MONT. CODE ANN. § 50-6-320(1) (West 2015).

<sup>135</sup> See *id.*; Lovshin, *supra* note 17, at 32.

<sup>136</sup> MONT. CODE ANN. § 50-6-320(2) (West 2015).

<sup>137</sup> For a detailed discussion of membership program concerns and how they work, see *infra* Part V., Section B.3.

<sup>138</sup> Lovshin, *supra* note 17.

program.”<sup>139</sup> Unlike what Mr. Lovshin contends, a subscriber is not covered only when the provider he or she subscribes to is the one to transport the subscriber. Section 50-6-320(3) actually requires air ambulance providers who take advantage of the exemption to work with other air ambulance providers to ensure their programs are transferrable amongst providers for the benefit of subscribers.<sup>140</sup> While not necessarily immune to potential legal challenges, this Montana statute appears to present a template that other states may be able to use to assist their citizens in making air ambulance services more affordable.<sup>141</sup>

## 2. Federal Level

State governments are not the only legislative bodies making efforts to regulate the air ambulance industry; there are some members of Congress who have recognized the importance of the issue and have made an effort to attempt to return some power back to the states. Coincidentally (or maybe not so), the two senators at the forefront of the congressional effort are from states that have already attempted to pass their own legislation regulating the air ambulance industry: Senator Jon Tester from Montana<sup>142</sup> and Senator John Hoeven from North Dakota.<sup>143</sup> Senator Tester and Senator Hoeven became the first members of Congress to attempt to reclaim air ambulance regulation for the states when they introduced Senate Amendment 3753.<sup>144</sup>

Amendment 3753, titled “State Prioritization of Dispatch of Air Ambulance Service Providers,” sought to grant states the power to pass legislation “that creates a primary and secondary call list of air ambulance service providers in the State for distribution to emergency response entities and personnel to prioritize the dispatch of air ambulance serve [sic] providers,” notwithstanding the ADA.<sup>145</sup> On April 13, 2016, Senators Tester and Hoeven introduced this proposed amendment less than a month after the United States District Court for the District of

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<sup>139</sup> MONT. CODE ANN. § 50-6-320(3) (West 2015).

<sup>140</sup> *See id.*

<sup>141</sup> *See infra* Part V., Section B.3.

<sup>142</sup> *See Biography*, JON TESTER, U.S. SENATOR FOR MONTANA, <http://www.testersenate.gov/?p=biography> [<https://perma.cc/SG24-GNXQ>] (last visited July 6, 2017).

<sup>143</sup> *See Biography*, U.S. SENATOR JOHN HOEVEN OF NORTH DAKOTA, <https://www.hoeven.senate.gov/about/biography> [<https://perma.cc/X4UH-BTWW>] (last visited July 6, 2017).

<sup>144</sup> *See* S. Amdt. 3753, 162 CONG. REC. S2048 (Apr. 13, 2016).

<sup>145</sup> *Id.*

North Dakota issued its ruling in *Valley Med Flight, Inc. v. Dwelle*.<sup>146</sup> As one of the senators from North Dakota,<sup>147</sup> Senator Hoeven was surely aware of the United States District Court for the District of North Dakota's decision, which may explain the similarities in language shared by Amendment 3753 and the North Dakota statute.<sup>148</sup> Unfortunately, Amendment 3753 "was ordered to lie on the table,"<sup>149</sup> meaning that the Senate wished to take a negative position on the amendment and wanted to express its final action on it.<sup>150</sup>

However, Senator Tester continued working for a way to give more power in the air ambulance arena back to the states. He cleared a huge obstacle on June 9, 2016, when the Senate Appropriations Committee submitted a report (accompanying the 2017 Labor, Health and Human Services, and Education Appropriations Bill) that included language directing the Government Accountability Office (GAO) to study "air ambulance services and payment structures."<sup>151</sup> While the Senate Appropriations Committee report itself does not immediately give states the power to regulate the air ambulance industry within their borders, Senator Tester stressed that this small victory was "a 'giant' step in the right direction."<sup>152</sup> Senator Tester elaborated on how Congress and states could use the results from the report, saying "[w]e don't have a lot of information on this quite frankly, and this will give us some information so that we can talk to the air ambulance services and potentially develop some rules around these air ambulances."<sup>153</sup> Having been approved by the Senate Appropriations Committee, the 2017 Labor, Health and Human Services, and Education Appropriations Bill was placed on the

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<sup>146</sup> See *id.*; *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930 (D.N.D. 2016) ("Signed March 21, 2016").

<sup>147</sup> See *Biography*, U.S. SENATOR JOHN HOEVEN OF NORTH DAKOTA, *supra* note 143.

<sup>148</sup> Compare S. Amdt. 3753, with N.D. CENT. CODE ANN. § 23-27-04.10 (West 2016).

<sup>149</sup> S. Amdt. 3753, 162 CONG. REC. S2048 (Apr. 13, 2016).

<sup>150</sup> *Enactment of a Law: Motions, Quorums, and Votes*, U.S. SENATE, [https://www.senate.gov/legislative/common/briefing/Enactment\\_law.htm#6](https://www.senate.gov/legislative/common/briefing/Enactment_law.htm#6) [<https://perma.cc/F5RS-NMCV>] (last visited July 6, 2017).

<sup>151</sup> S. REP. NO. 114-274, at 128 (2016).

<sup>152</sup> Angela Marshall, *Air Ambulance Reform Effort Passes U.S. Senate Committee*, ABC FOX MONTANA (June 9, 2016), <http://www.abcfoxmontana.com/story/32188525/air-ambulance-reform-effort-passes-us-senate-committee> [<https://perma.cc/Z6R4-4Q7H>].

<sup>153</sup> *Id.*

Senate Legislative Calendar on June 9, 2016.<sup>154</sup> Once the GAO submits its report, members of Congress will have more information that highlights the importance of this issue. Senator Tester's Communication Director Marnee Banks emphasized the need for more information when discussing Senator Tester's and Senator Hoeven's earlier failed effort: "This is the first time the Senate has tackled the issue of these outrageously high prices of air ambulances. So it is going to take a while for [Senator Tester] and Senator Hoeven to educate their colleagues on [its] importance . . . ." <sup>155</sup> With more than 550,000 patients using air ambulances each year,<sup>156</sup> education is sorely needed, and will ideally lead to congressional action in the near future.

## V. WHY SHOULD AIR AMBULANCES FALL OUTSIDE THE ADA?

A person in the middle of a medical emergency requiring air transport for treatment does not have the luxury of making sure that the transporting air ambulance is a provider covered by the patient's insurance, nor does the patient have the luxury of even inquiring as to the price of using such a service.<sup>157</sup> To account for this problem, this article argues that Congress must exempt air ambulances from the purview of ADA preemption because of conflicting congressional intent, because Supreme Court precedent has all but handcuffed the courts, and because of the severe inequality of power that exists in the air ambulance provider-patient relationship.

### A. CONGRESSIONAL INTENT

When interpreting express preemption clauses, the "task is to ascertain Congress' intent in enacting the federal statute at issue."<sup>158</sup> The United States District Court for the District of North Dakota in *Valley Med Flight, Inc. v. Dwelle* said that legislation intending "to prevent air ambulance service providers . . . from imposing exorbitant fees on patients . . . is precisely the

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<sup>154</sup> *Appropriations for Fiscal Year 2017*, CONGRESS.GOV, <https://www.congress.gov/resources/display/content/Appropriations+or+Fiscal+Year+2017> [https://perma.cc/4QRS-AF74] (last visited July 7, 2017).

<sup>155</sup> Corin Cates-Carney, *Air Ambulance Reform Effort Dies in US Senate*, MONTANA PUBLIC RADIO (Apr. 15, 2016), <http://mtpr.org/post/air-ambulance-reform-effort-dies-us-senate> [https://perma.cc/K79X-X6LR].

<sup>156</sup> See *Consumer Alert: Understanding Air Ambulance Insurance*, *supra* note 20.

<sup>157</sup> See Jordon, *supra* note 38.

<sup>158</sup> *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 95 (1983).

type of law Congress sought to preempt when it enacted the ADA.<sup>159</sup> While Congress has demonstrated its intent “to rest sole responsibility for supervising the aviation industry with the federal government,”<sup>160</sup> Congress surely did not intend to allow providers to charge exorbitant fees on patients concerned about their health. Many of the courts rely on the argument that state statutes regulating the air ambulance industry are the exact type of laws that Congress meant to preempt when it enacted the ADA.<sup>161</sup> However, would Congress really intend for medical patients to be taken advantage of just to get treatment that could save their lives? While there is evidence to suggest that Congress did not intend for the ADA to preempt safety measures,<sup>162</sup> the ADA makes it clear that Congress *did* intend to preempt pricing regulations imposed by states.<sup>163</sup> The point where one draws the line between price and safety is unclear. Equally unclear is whether the law views one as being out-and-out more important than the other, or whether the two are to be treated equally, notwithstanding any arguments of morality.

An analysis of the legislative intent behind the ADA sheds light on Congress’ true goals when passing the ADA.<sup>164</sup> When examining legislative or “statutory intent,” the starting point is “the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose.”<sup>165</sup> The policy statement contained in 42 U.S.C. § 40101 confirms that Congress felt “assigning and maintaining safety [was] the highest priority” and that Congress is committed to “preventing deterioration in established safety procedures . . . .”<sup>166</sup> Further, Congress noted that its “clear intent, encouragement, and dedication [is] to further the highest degree of safety in air transportation . . . .”<sup>167</sup> As air ambulances are a medical service,<sup>168</sup> surely the air ambulance industry would fall under the safety umbrella.

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<sup>159</sup> *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 942 (D.N.D. 2016).

<sup>160</sup> *Abdullah v. Am. Airlines, Inc.*, 181 F.3d 363, 368 (3d Cir. 1999).

<sup>161</sup> *See, e.g., Dwelle*, 171 F. Supp. 3d at 942; *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 736 (E.D.N.C. 2008).

<sup>162</sup> *See Resendiz*, *supra* note 16, at 343–44.

<sup>163</sup> *See* 49 U.S.C. § 41713(b)(1) (2012).

<sup>164</sup> *See Resendiz*, *supra* note 16, at 343.

<sup>165</sup> *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992) (internal quotation marks omitted).

<sup>166</sup> 49 U.S.C. §§ 40101(a)(1), (a)(3) (2012).

<sup>167</sup> 49 U.S.C. § 40101(a)(3) (2012).

<sup>168</sup> *See supra* Part II.



However, the plain language of the ADA makes it clear that Congress meant to preempt state regulation of prices charged by air ambulance providers.<sup>169</sup> Thus, an inevitable conflict exists between whether state air ambulance regulations control measures governing the safety of patients or whether they control prices. The answer, in reality, appears to be that under the ADA, state air ambulance regulations can control either measures associated with patient safety *or* prices. Clearly, the courts have taken the position that the state regulations discussed herein lean toward the pricing side of the conflict.<sup>170</sup> On the other hand, there are instances holding that some issues are not preempted, therefore allowing the states to regulate some air ambulance issues. Those issues revolve largely around aspects related to the quality and standard of medical care given to patients.<sup>171</sup> While these findings do not provide a conclusive answer to the question, because of this dichotomy it appears state regulation must relate to standards of medical care in some capacity if they are to survive ADA preemption challenge.

Preemption is no longer the best option because competition does not effectively serve emergency medical situations. Congress enacted the ADA after determining “that deregulation of the airline industry would lead to greater reliance on market forces resulting in greater efficiency, innovation, lower prices, and enhanced quality and variety of air transportation services.”<sup>172</sup> Congress thought this “reliance on competitive market forces and on actual and potential competition” would best serve the aircraft industry.<sup>173</sup> Congress even included a preemption provision in the ADA to prevent states from getting around deregulation by passing their own regulatory laws.<sup>174</sup> However, Congress was also clear in the difference between safety and

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<sup>169</sup> See 49 U.S.C. § 41713(b)(1) (2012); see also *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 942 (D.N.D. 2016).

<sup>170</sup> See, e.g., *Dwelle*, 171 F. Supp. 3d at 942; *Eagle Air Med Corp. v. Colorado Bd. of Health*, 570 F. Supp. 2d 1289, 1292 (D. Colo. 2008) (citing *Morales*, 504 U.S. at 388, 390–91).

<sup>171</sup> See *Hiawatha Aviation of Rochester, Inc. v. Minnesota Dep’t of Health*, 389 N.W.2d 507, 509 (Minn. 1986); GAO-10-907, at 23 tbl.3, 36–40 app. III (2010) (reproduced *infra* Appendix); Lovshin, *supra* note 17, at 34 (“states do have limited regulatory authority over air ambulance providers around medical and quality standards of care”).

<sup>172</sup> *Dwelle*, 171 F. Supp. 3d at 938 (citing *Morales*, 504 U.S. at 378).

<sup>173</sup> 49 U.S.C. § 40101(a)(6) (2012).

<sup>174</sup> See *Morales*, 504 U.S. at 378.

pricing regulations.<sup>175</sup> Clearly Congress believed that a competitive market would lead to lower prices, but it is doubtful that Congress would really intend for competition to govern the safe, timely, and effective administration of healthcare in emergency situations.

However, competition won out against healthcare services in *Med-Trans Corp. v. Benton*, where the court found that North Carolina's prescription of behavior (requiring a certificate of need) necessary for an air ambulance provider to operate in the state directly contravened the pro-competition purposes of the ADA, and those requirements limiting the ability of an air ambulance provider to operate in the state were thus related to the provider's prices, routes, or services.<sup>176</sup> Additionally, in *Valley Med Flight, Inc. v. Dwelle*, the court actually ruled in favor of a result that was the direct opposite of what Congress intended.<sup>177</sup> By holding that the North Dakota statute was preempted, the court essentially said that the state could not "prevent air ambulance service providers, who are not participating providers, from imposing exorbitant fees on patients."<sup>178</sup> That flies directly in the face of Congress' intent in enacting the ADA: that a competitive market would lead to lower prices.<sup>179</sup>

#### B. PATIENTS REMAIN AT THE MERCY OF PROVIDERS DUE TO UNEQUAL BALANCE OF POWER

Air ambulance providers control virtually every aspect of air ambulance services, and oddly enough, the patient has little to no control. From setting the price, to working with different insurance carriers, the air ambulance providers are in near-total control. The patient is simply along for the ride. The following subsections will discuss the costs of air ambulance services, the complications that come with in-network versus out-of-network providers, and a possible template for state action based on the Montana statute.<sup>180</sup>

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<sup>175</sup> See *supra* Part V., Section A.

<sup>176</sup> *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 736 (E.D.N.C. 2008).

<sup>177</sup> *Dwelle*, 171 F. Supp. 3d at 942.

<sup>178</sup> *Id.*

<sup>179</sup> See *Morales*, 504 U.S. at 378.

<sup>180</sup> MONT. CODE ANN. § 50-6-320 (West 2015) (discussed in Part IV., Section C.1.g.).

### 1. *Costs of Services*

Use of an air ambulance can be an expensive event. The average air ambulance trip will cost \$12,000 to \$25,000 per flight, before insurance kicks in.<sup>181</sup> Providers justify the costly charges by citing the cost of equipment,<sup>182</sup> maintenance, their round-the-clock on-call flight and medical personnel, and the intrinsic value of the air ambulance service.<sup>183</sup> When setting prices, providers must estimate the volume of patient transports and how many of those transports will and will not end up paying for the service.<sup>184</sup> Some air ambulance providers recognize the costs of their services, and offer programs designed to help would-be patients in the future. For example, LifeNet, for an annual fee of just \$49, will pay \$10,000 if a subscriber's family member has a medical necessity that requires transportation by air ambulance.<sup>185</sup> Some air ambulance providers have also created membership-based subscription programs that will cover transport between hospitals<sup>186</sup> or that can cover the patient's full cost when that patient needs an air ambulance.<sup>187</sup> However, membership programs come with a large caveat: generally, to take advantage of the benefits offered by a membership subscription, the provider that offers the membership must be the air ambulance that transports the patient.<sup>188</sup> Unfortunately, patients often do not have any input or choice in the air ambulance provider that responds when they require transport.<sup>189</sup>

### 2. *Choice of Provider: In-Network vs. Out-of-Network Providers*

When an air ambulance provider is part of an insurance carrier's network (in-network), the provider accepts the reimbursement rate of the insurance carrier, and any additional cost to the patient is written off.<sup>190</sup> In contrast, an out-of-network provider may accept the reimbursement rate of the insurance car-

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<sup>181</sup> See *DIFS Consumer Counselor Insurance Information Sheet*, *supra* note 26; see also *Consumer Alert: Understanding Air Ambulance Insurance*, *supra* note 20.

<sup>182</sup> See *DIFS Consumer Counselor Insurance Information Sheet*, *supra* note 26 ("The high price accounts for the initial aircraft cost which can reach \$6 million . . .").

<sup>183</sup> See Lovshin, *supra* note 17.

<sup>184</sup> See Bernard F. Diederich, *Air Ambulance, Rescuer or Rescued?*, 62 *FED. LAW.* 67, 71 (2015).

<sup>185</sup> See Jordon, *supra* note 38.

<sup>186</sup> See *id.*

<sup>187</sup> See GAO-10-907, at 6 n.7.

<sup>188</sup> See *id.*

<sup>189</sup> See *infra* Part V, Section B.2.

<sup>190</sup> See Jordon, *supra* note 38.

rier, but has the option to balance bill<sup>191</sup> the patient for the remainder of the cost.<sup>192</sup> However, patients rarely are aware whether the air ambulance that responds is in-network or out-of-network.<sup>193</sup> Even worse, in emergency situations, patients may not even be capable of asking if the ambulance is an in-network provider, or what their insurance coverage looks like.<sup>194</sup> Douglas County's Chief Deputy Sheriff Tom Wheeler said: "A lot of times the person is unconscious or there's trauma or shock. We're not asking them what to do. We're providing the best response we can, and you've got to make decisions right now."<sup>195</sup>

The patient is typically not even the party that requests an air ambulance; that determination falls to the paramedics on the scene, and scope of insurance coverage is a non-factor in that decision.<sup>196</sup> Even the providers do not consider whether they are in or out of a patient's coverage network; such is the case with emergency situations, where every second counts.<sup>197</sup>

### 3. *A Possible Template for State Action*

States looking to "assist [their] consumers with regard to the availability and affordability of air ambulance service" may be able to take a cue from the Montana statute.<sup>198</sup> As an incentivizing measure, rather than a regulatory one, statutes similar to the Montana statute may be better equipped to survive ADA challenge. Air ambulance providers would actually be making "a business decision" when they choose to take advantage of whatever exemptions or benefits the state chooses to offer in exchange for compliance with the statute (in the Montana statute, the state exempted providers from insurance statutes),<sup>199</sup> and would not be forced into working with other providers in order to continue operating. This would overcome the point

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<sup>191</sup> See *supra* text accompanying notes 39–40.

<sup>192</sup> See Jordon, *supra* note 38.

<sup>193</sup> See Springer, *supra* note 1.

<sup>194</sup> Kathleen Woodford, *Air Ambulance Charges Can Reach \$100,000*, CLARK FORK VALLEY PRESS (May 4, 2016), <https://www.testersenate.gov/?p=news&id=4566> [<https://perma.cc/E68W-49ZJ>].

<sup>195</sup> See Jordon, *supra* note 38.

<sup>196</sup> See *id.*

<sup>197</sup> See *id.* ("In emergencies, 'we never even ask . . . We just respond. Insurance never comes to our thoughts at that time. Hopefully they have insurance, and if they don't, we work with them on a case-by-case basis.'").

<sup>198</sup> MONT. CODE ANN. § 50-6-320(1) (West 2015); see discussion *supra* Part IV., Section C.1.g.

<sup>199</sup> See § 50-6-320(2).

made by the court in *Valley Med Flight, Inc. v. Dwelle*.<sup>200</sup> Providers would only have to work with other providers and accept membership programs offered by other providers if they wanted to be exempted from insurance statutes: “Any private air ambulance service membership program must have arrangements with other air ambulance service providers in [the state] to the extent reasonably possible to ensure maximum geographic coverage within the state for the subscribers to the program.”<sup>201</sup> If the provider does not wish to work with other providers, they can carry on with business as usual, and will not be in danger of having to cease operations as a result.<sup>202</sup>

Subscription-based membership programs do not escape the problems facing the air ambulance industry, nor are they a perfect solution. For patients to benefit from these programs, generally the transporting provider must be the same one that offers the membership subscription.<sup>203</sup> But, since patients have little say in what provider picks them up,<sup>204</sup> they cannot be sure that their subscription will cover their use of the air ambulance. The Montana statute solves this conundrum. To take advantage of the benefits that accompany exemption from insurance statutes, providers must arrange with other air ambulance providers to reasonably “ensure maximum geographic coverage within the state for the subscribers to the program.”<sup>205</sup> More providers accepting the subscriptions offered by rival providers would noticeably increase the likelihood that a responding air ambulance provider would accept the membership subscription of a patient. This would avoid patients having to worry about whether it will be their subscribing provider that responds, and would also keep patients from sacrificing valuable time waiting for their subscribing provider to be available to respond. While it would be imprudent to suggest that every air ambulance provider within a state would avail themselves of the benefits offered by

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<sup>200</sup> See *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 941 (D.N.D. 2016) (“The State argues that becoming a ‘participating provider’ is simply a business decision made by air ambulance operators. However, it is clear to the Court that air ambulance operators who work in the North Dakota market have no choice but to become a ‘participating provider’ (and accept an insurer’s rates) or discontinue operating in the state.”).

<sup>201</sup> § 50-6-320(3).

<sup>202</sup> See §§ 50-6-320(2), (3).

<sup>203</sup> See GAO-10-907, at 6 n.7.

<sup>204</sup> See *supra* Part V., Section B.2.

<sup>205</sup> § 50-6-320(3).

such a statute, one might presume that some air ambulance providers would explore the opportunity.

This approach does not solve the overall issue, but is a step in a more affordable direction. While consumers would have to purchase membership subscriptions in order to benefit, if statutes like this were to become more commonplace, that small investment could mean a difference of multiple thousands of dollars in the event an air ambulance is needed.<sup>206</sup> It is important to note that the Montana statute has yet to be challenged on ADA preemption grounds, but as it is merely incentivizing, not prescriptive, there is reason to believe that it would survive such a challenge.

### C. PRECEDENT LEAVES NO OTHER OPTION

Decisions by the Supreme Court and lower courts appear to have halted efforts by state legislators in their tracks.<sup>207</sup> Further, despite the intentions of Congress, it is increasingly clear that the courts are handcuffed on the inevitable conflict created by this issue.<sup>208</sup>

*Chandler v. Roudebush*<sup>209</sup> seems to support the argument that the federal courts should take up the air ambulance industry preemption issue. The Court noted that issues that “require[ ] non-partisan judgment” are best heard by federal judges.<sup>210</sup> This is because federal jurists are, in theory, shielded from outside influence.<sup>211</sup> Given the unequal balance of power that exists between patients and providers, the air ambulance industry preemption issue clearly would benefit from non-partisan judgment.<sup>212</sup> As numerous federal courts have already addressed the issue, that leaves the Supreme Court as the best judicial option. The Court should be able to remove politics from the

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<sup>206</sup> Compare GAO-10-907, at 6 n.7, with *DIFS Consumer Counselor Insurance Information Sheet*, *supra* note 26 (“The average air ambulance trip . . . costs between \$12,000 to \$25,000 per flight.”).

<sup>207</sup> See, e.g., *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219 (1995); *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374 (1992); *Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 942 (D.N.D. 2016).

<sup>208</sup> See *Dwelle*, 171 F. Supp. 3d at 942 (“While the policy choices the State is attempting to impose . . . are well-intentioned and enacted in good faith, it is clear that Congress has assumed the field in the arena of air carrier regulation and noble intent does not save the law from preemption.”).

<sup>209</sup> 425 U.S. 840 (1976).

<sup>210</sup> *Id.* at 851 (internal quotations omitted).

<sup>211</sup> See *id.*

<sup>212</sup> See *supra* Part V., Section B.

formula completely, as the life tenure enjoyed by Supreme Court justices would, theoretically at least, make the Court “more likely to withstand political pressures and render their decisions in a climate tempered by judicial reflection and supported by historical judicial independence.”<sup>213</sup>

Indeed, the Supreme Court has addressed the preemption issue. In *American Airlines, Inc. v. Wolens*, the Court held that the ADA preempted prescriptive, conduct-controlling laws.<sup>214</sup> The problem facing states post-*Wolens* is figuring out how they can regulate the air ambulance industry without controlling air ambulance providers’ conduct. That problem is multiplied when reminded of the Supreme Court’s earlier holding in *Morales v. Trans World Airlines, Inc.* that the ADA’s broad preemptive purpose stems from the “relating to” language.<sup>215</sup> It would appear to be a difficult road for state lawmakers to pass legislation that could survive scrutiny under both *Morales* and *Wolens*.

In *United States v. Carolene Products Co.*, the Supreme Court expressed the idea that there would be general discretion to the legislature as to the laws that are passed, in the assumption that they “rest[ ] upon some rational basis within the knowledge and experience of the legislators.”<sup>216</sup> The Court also suggested, in the famous footnote that has come to be known as “the most important footnote in constitutional law,”<sup>217</sup> that the judicial system can step in to prevent the legislative exploitation of those in weaker or less powerful positions, especially when there “may be a special condition, which tends seriously to curtail the operation of those political processes ordinarily to be relied upon . . . .”<sup>218</sup> In the case of the air ambulance industry, there is such a special condition: federal courts repeatedly holding that state regulation of the air ambulance industry is preempted by the ADA,<sup>219</sup> as well as the holdings in *Morales*<sup>220</sup> and *Wolens*.<sup>221</sup> The holdings in these cases have effectively shut off the ability of

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<sup>213</sup> *Chandler*, 425 U.S. at 851 (internal quotations omitted).

<sup>214</sup> *Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 227–28 (1995).

<sup>215</sup> *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992).

<sup>216</sup> *See United States v. Carolene Products Co.*, 304 U.S. 144, 152 (1938).

<sup>217</sup> Lincoln Caplan, *Ruth Bader Ginsburg and Footnote Four*, THE NEW YORKER, Sept. 13, 2013.

<sup>218</sup> *See Carolene Products*, 304 U.S. at 152 n.4.

<sup>219</sup> *See, e.g., Valley Med Flight, Inc. v. Dwelle*, 171 F. Supp. 3d 930, 942 (D.N.D. 2016); *Med-Trans Corp. v. Benton*, 581 F. Supp. 2d 721, 736 (E.D.N.C. 2008).

<sup>220</sup> *See Morales*, 504 U.S. at 383.

<sup>221</sup> *See Am. Airlines, Inc. v. Wolens*, 513 U.S. 219, 227–28 (1995).

state lawmakers to pass legislation regulating the air ambulance industry that will protect their citizens.

However, the courts have about as much likelihood of successfully ruling in favor of state regulation as state lawmakers do, as *Northwest, Inc. v. Ginsberg* suggests that the ADA preempts state common law developed by the courts.<sup>222</sup> While the Supreme Court could still easily address the issue by nature of its chief status, doing so would fly in the face of years of precedent because it would directly oppose *Ginsberg*. Further, while the Supreme Court is a possible option to resolve this issue, there is a temporal component to the issue as well: it can take years before a case is adjudicated by the Supreme Court. That rules out waiting on the Supreme Court as the best option, as countless patients will suffer in the meantime.<sup>223</sup> By process of elimination, responsibility for regulating the air ambulance industry falls to the United States Congress. In the wake of *EagleMed, LLC v. Wyoming*, the Wyoming Insurance Commissioner, Tom Glause, even went so far as to opine that “Congress needs to exempt the air ambulances from the Aviation Deregulation Act. ‘Once that happens, then the states can take a look at it and address legislation to deal with the issue . . . .’”<sup>224</sup>

## VI. CONCLUSION

In times of serious medical crisis, patients depend on emergency services personnel to arrive quickly and transport them so that they may receive life-saving treatment. The air ambulance industry has grown a great deal since its beginnings on the battlefields of World War I, and advances in technology have helped develop the industry. However, because of legal precedent and air ambulance industry norms, medical patients are the ones who suffer under the ADA. Maintaining that technology and staffing air ambulances is expensive, and without regulation, the patient is left to figure out how to pay an expensive bill while recovering from the injuries he sustained. The legal framework of the ADA has left the courts handcuffed, forcing

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<sup>222</sup> *Northwest, Inc. v. Ginsberg*, 134 S. Ct. 1422, 1429–30 (2014).

<sup>223</sup> See *Consumer Alert: Understanding Air Ambulance Insurance*, *supra* note 20 (“The Association of Air Medical Services estimates that more than 550,000 patients in the U.S. use air ambulances each year.”).

<sup>224</sup> Ben Neary, *Federal Judge Rejects Wyoming Air Ambulance Regulation*, WASH. TIMES (May 25, 2016), <http://www.washingtontimes.com/news/2016/may/25/federal-judge-rejects-wyoming-air-ambulance-regula/> [https://perma.cc/PPG2-SMA2].



them to find state attempts at regulation to be preempted by the ADA, no matter the intent behind the regulatory legislation.

The best solution is for Congress to exempt air ambulances from ADA preemption. Congressional intent shows that safety and aspects of medical care are not meant to be preempted. The cost of an air ambulance transport is as much a part of medical care as the surgery that follows transportation. The fact that the ambulance is a helicopter or a plane rather than a ground vehicle should not be a determining factor, especially when an air ambulance is the only available method of transport. Competition governs in a business setting, but in a life and death healthcare situation, patients need the best available options, not unpaid bills.